WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (950)

11600

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 910 Maryland Avenue

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Morgan

City or town: Paw Paw Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Lucy Jane Alderton

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: J. V. Alderton

Dead 6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 16, 1868

8. AGE:

Years	Months	Days	If less than one day
71	5	9	____ hrs. ____ min.

9. Birthplace: Hampshire County, W.Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Moreland
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Margaret Martin
15. Birthplace: West Virginia

16. Informant: Mrs G. C. MacDonald

Address: 910 Maryland Ave. Cumberland

17. Removal
(Burial, cremation, or removal. Which?)

Date thereof: 12 (month) 27 (day) 1939 (year)

Cemetery ~~or crematory~~: Camp Hill

Location: Paw Paw, W. Va

18. Funeral director: Jacob Hofer

Address: Cumberland Md

19. Dec. 28, 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/25/39 19____, at 11 p M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from 12/23/39 19____, to 12/25/39, and that I last saw h[illegible] alive on 12/22/39 19____.

Immediate cause of death: Cardiac Thrombosis

Due to: Hypertension

Due to: Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Richard J. Wittmann MD
M. D. or other

Address: 34 Va. Ave. Date signed 12/27/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

11601

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 441 Walnut

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 yrs 2 M. 15 dys

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State W. Va County Grant

City or town Tormonia Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Ellen Baer

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife George Baer

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1863

8. AGE: Years 76 | Months 6 | Days 4 | If less than one day hrs. min.

9. Birthplace Somerset, Somerset, Penn. (Town, county, and state)

10. Usual occupation House-wife

11. Industry or business

FATHER: 12. Name John Baker

13. Birthplace Not known

MOTHER: 14. Maiden name Sydia Shumaker

15. Birthplace Meyersdale, Penn.

16. Informant Mrs Ross Burton

Address Westernport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4 1939 (month) (day) (year)

Cemetery or crematory Naggie

Location 10 Miles South Oakland, Md

18. Funeral director D. S. Boal

Address Westernport, Md.

19. Dec. 4 1939 (Date rec'd by registrar) J. Raymond Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1939, at 1:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1939, to Dec 2 1939, and that I last saw her alive on Dec 2 1939.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 13 days

Due to Arteriosclerosis — 5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P E Berry M.D. M. D. or other

Address Piedmont Wva Date signed 12/4/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (212m)

11602

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing, Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) –

Stay in this community (yrs., or mos., or days) 10 yrs 3 mos 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. –
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR –

3. (a) FULL NAME Aleck M. Beeman

3. (b) Social Security Number –

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: –

6 (b) Name of husband or wife –

6(c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) August 24, 1929

8. AGE: Years 10 | Months 3 | Days 6 | If less than one day ___ hrs. ___ min.

9. Birthplace Lonaconing, Md
(Town, county, and state)

10. Usual occupation School Boy

11. Industry or business –

FATHER
12. Name William Beeman
13. Birthplace Lonaconing, Md

MOTHER
14. Maiden name Effie Beeman
15. Birthplace Gilmore, Md

16. Informant Mrs Effie Beeman
Address Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3, 1940 (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Moscow, Md

18. Funeral director M. Eichhorn
Address Lonaconing, Md

19. Jan. 2nd 1940 (Date rec'd by registrar) Dr. E. Don Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1939, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1939, to Dec 31 1939, and that I last saw her alive on Dec 31 1939.

Immediate cause of death	DURATION
Acute Peritonitis	12 hr.
Due to	
Due to abdominal contusion	3 days.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide accident Date of Dec. 28 1939

Where did injury occur? Lonaconing (City or town) (County) Md (State)

Injured at home, farm, industry, public place (where?) Sled riding on hill, public street – hit parked auto.

Means of injury Injured at work?

23. SIGNATURE E. Don Taylor M. D. or other

Address Lonaconing Date signed Jan 2 1940

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94C)

CERTIFICATE OF DEATH

11603

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Walton Hotel - Cumberland, Md

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (Ward No.)
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Walton Hotel, Cumberland Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: James Francis Birmingham

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 4, 1872

8. AGE: Years: 67 | Months: 8 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Boiler Maker

11. Industry or business: Railroads

FATHER 12. Name: James Birmingham

13. Birthplace: Vermont

MOTHER 14. Maiden name: Augnes Mc Mahon

15. Birthplace: Albany, N. Y.

16. Informant: Joseph D. Birmingham

Address: 187 N. Johnson St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4, 1939. (month) (day) (year)

Cemetery or crematory: St. Patricks Cemetery

Location: Mt. Savage Md.

18. Funeral director: Jacob Hafer

Address: Cumberland Md.

19. Dec. 2 (Date rec'd by registrar) 19 39 J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1st., 1939, at about 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: no autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thomas H. Brown M.D.
M. D. or other

Address: Cumberland, Md. Date signed 12/2/39

Deputy Medical Examiner - Allegany Co.

RECEIVED
JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

11604

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Rawlings, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): one week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: New Creek Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Martha Jane Biser

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B (b) Name of husband or wife: Nicholas Biser

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 2, 1865

8. AGE: Years	Months	Days	If less than one day
74	2	29	hrs. min.

9. Birthplace: Hardy Co. W.Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel Leatherman
13. Birthplace: Virginia

MOTHER
14. Maiden name: Hannah Merrit
15. Birthplace: Unknown

16. Informant: Ira A. Biser
Address: New Creek, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 2, 1940 (month) (day) (year)

Cemetery or crematory: Beaver Run

Location: Hampshire Co. W.Va.

18. Funeral director: N.H. Rogers

Address: Keyser, W.Va.

19. Jan. 2 (Date rec'd by registrar) 19 40 A. J. Baynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 31, 1939, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1939, to Dec 31 1939, and that I last saw h alive on Dec 31 1939.

	DURATION
Immediate cause of death: Bronchio Pneumonia	12/29/39
Due to	
Due to	
Other conditions: Chr Myocarditis Hypertension (Include pregnancy within 3 months of death)	

Major findings:

Df operations:

Df autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. W. Reese M.D. M. D. or other

Address: Westernport Md. Date signed: 1/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11605

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Paw Paw Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Miss Beulah Mae Blackburn

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Single

B (b) Name of husband or wife: X

6(c) If alive, give age: X years

7. Birth date of deceased (mo., day, yr.): December 22, 1938

8. AGE:

Years	Months	Days	If less than one day
	11	20	hrs. min.

9. Birthplace: Paw Paw, Mineral, W. Va.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Leroy Blackburn

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Pearl Zemhower

15. Birthplace: Penna.

16. Informant: Leroy Blackburn

Address: W. Va., Paw Paw

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-14-1939 (month) (day) (year)

Cemetery or crematory: Centerville Cemetery

Location: Centerville, Pa.

18. Funeral director: Jacob Hofer

Address: R3/6 Baltimore Ave.

19. Dec. 13, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12 — 1939, at 7:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8th 1939, to Dec 12 1939, and that I last saw her alive on Dec 12 — 1939

Immediate cause of death	DURATION
Acute pneumonitis	2 Wks
Due to Influenza	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: C. L. Owens M D (M. D. or other)

Address: Cumberland Md Date signed 12-12-39

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31)

CERTIFICATE OF DEATH

11606

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 40 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Woodlawn, La Vale
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME: George W. Bowser

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Tirzah ?
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 22, 1869

8. AGE: Years	Months	Days	If less than one day
70	5	13	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Pensioned
11. Industry or business:
FATHER 12. Name: Daniel Bowser
13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Amanda ?
15. Birthplace: Pennsylvania
16. Informant: Memorial Hospital
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 8, 1939 (month) (day) (year)
Cemetery or crematory: German Valley Cem.
Location: Shirleysburg, Penna.
18. Funeral director: J. C. Wolford
Address: Cumberland, Md.
19. Dec. 6, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. ELIASON

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5, 1939 at 3:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec-1 1939 to Dec-2 1939 and that I last saw him alive on Dec-5 1939

Immediate cause of death	DURATION
Chronic Myocarditis	4 yrs
Chronic Nephritis	2 yrs
Due to Arteriosclerosis	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. U. Eliason M. D. or other
Address 126 Union St. Cumberland Date signed 12/6/39

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-c)

CERTIFICATE OF DEATH

Md. La 11607

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Shaft, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or Inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Shaft Ward, No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Conrad Brode

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Sophia Jane Brode
6(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 4, 1862

8. AGE:

Years	Months	Days	If less than one day
77	8	17	hrs. min.

9. Birthplace: Frostburg Md.
(Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal mines
FATHER 12. Name: Conrad Brode
13. Birthplace: Germany
MOTHER 14. Maiden name: Anna Martha
15. Birthplace: U.S.
16. Informant: George Brode
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24, 1939 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: J. J. Hurst
Address: Frostburg Md.
19. 12-23-39 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21 1939, at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 1939, to Dec 21 1939, and that I last saw h- alive on Dec 20 1939.

Immediate cause of death: Chronic Myocarditis — DURATION: ?
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury — Injured at work?

23. SIGNATURE: W. M. McLane Jr. M.D.
M. D. or other
Address: Frostburg Md. Date signed: Dec 23 1939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 9 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107-a

CERTIFICATE OF DEATH

11608

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County: Alleghany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 442 Walnut St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 442 Walnut St.

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Catherine Brooks

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband ~~or wife~~: J. J. Brooks

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 2 1876

8. AGE:

Years	Months	Days	If less than one day
68	4	19	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER — 12. Name: Thomas Lavin

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Catherine Cane

MOTHER — 15. Birthplace: Ireland

16. Informant: J. J. Brooks

Address: 442 Walnut St. city

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 29 1939 (month) (day) (year)

Cemetery or crematory: St. Peter & Paul's

Location: City

18. Funeral director: Virgil L. Kesperman

Address: Cumberland Md.

19. Dec. 29 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26 1939, at 10 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/15/38 19 to 12/26 1939, and that I last saw ~~her~~ alive on 12/26/39 19

Immediate cause of death	DURATION
Hypostatic Bronchopneumonia	2 days
Due to myocardial failure	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John K. Rozzell M.D. M. D. or other

Address: Cumberland Date signed 12/29/39

mc

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

11609

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(17)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 213 Wallace St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 213 Wallace St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Henry Brown

3. (b) Social Security Number

4. Sex male

5. Color or race Colored

6. (a) Single, married, widowed, or divorced married

6 (b) ~~Name of husband or~~ wife Mary E Cook

6(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) June 8 1879

8. AGE: Years 60 Months 5 Days 23 If less than one day ___ hrs. ___ min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation Janitor

11. Industry or business

FATHER
12. Name John H Brown
13. Birthplace Md.

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Mary E Brown

Address 213 Wallace St

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Dec 4 1939
(month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

19. Dec. 3 1939 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1, 1939, at 4:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 1939, to Dec 1 1939, and that I last saw him alive on Nov. 29, 1939.

Immediate cause of death Acute Encephalitis — DURATION 15 days

Acute Parenchymatous nephritis

Due to Hypertension — 8 yrs.

Due to Encephalitis lethargica. C.W.R.

Other conditions Edema of Lungs — 2 days
(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Hollowand M.D.
M. D. or other

Address 145 Hanover St. Date signed Dec 3 1939

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126-a)

11610

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 1209 Virginia Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1209 Virginia Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Diana Burton

3. (b) Social Security Number ✓

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ Richard Burton

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1852

8. AGE: Years 87 | Months 4 | Days 0 | If less than one day ____ hrs. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name Jacob Crous
13. Birthplace Va.

MOTHER
14. Maiden name Evelyn Caplit
15. Birthplace Va.

16. Informant Vincent Burton

Address 1209 Virginia, Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 20 1939 (month) (day) (year)

Cemetery or crematory Woodrow Cemetery

Location near Paw Paw

18. Funeral director Louis Stein Inc.

Address 117 Frederick St

19. Dec. 18, 1939 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1939, at 9 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 1939, to Dec 17 1939.

and that I last saw her alive on Dec 17 1939.

Immediate cause of death Fracture left femur

Due to accidental fall on room floor

Due to Chronic Valvular heart disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

CURATION: Dec 4 1939. about 13 yrs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external ~~causes~~, fill in the following:

Accident, suicide, or homicide Accident Date of Dec 4 39

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Injured at work?

23. SIGNATURE Mrs E B Owens M. D. or other

Address 133 Va av Date signed 12/18/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (82nd) Reg. Dist. No. 8

CERTIFICATE OF DEATH

11611

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Midland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Main St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 54 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Midland (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? 78 years

3 (a) FULL NAME Mary Catherine Byrne

3 (b) If veteran, name war ✓ | 3 (c) Social Security No. ✓

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1851

8. AGE: Years 88 | Months 10 | Days 16 | If less than one day ____hr. ____min.

9. Birthplace Scotland, Yorkshire Co. (Town, county, and state)

10. Usual occupation None, (Invalid)

11. Industry or business

FATHER 12. Name Miles Byrnes
13. Birthplace Ireland

MOTHER 14. Maiden Name Anne Cavanaugh
15. Birthplace Ireland

16 (a) Informant Catherine A. Gladden
(b) Address Midland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20 1939 (month) (day) (year)
(c) Cemetery or crematory St. Michaels Cem
Location Frostburg

18 (a) Funeral director D. S. Royal
(b) Address Barton, Md.

19 (a) Dec. 19-1939 (Date rec'd by registrar) (b) E. Don Taylor Registrar

MEDICAL CERTIFICATION

20. Date of death December 18 1939, at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1939, to Dec 16 1939, and that I last saw her alive on Dec 16 1939.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. Shelton Jr. M. D. (M. D. or other)
Address Midland, Md. Date signed Dec. 19/1939

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1940
BUREAU V. S.

OUTSIDE CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (210-m)

CERTIFICATE OF DEATH

11612

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Mc Mullen Hosp. (City)
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cresaptown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Leo Glenwood Cecil

3. (b) Social Security Number: 714-07-2180

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife: Viola Kimbel

6(c) If alive, give age: 23 years

7. Birth data of deceased (mo., day, yr.): March 14, 1914

8. AGE: Years	Months	Days	If less than one day
25	9	7	hrs. min.

9. Birthplace: Cresaptown, Allegany Co. Md.
(Town, county, and state)
10. Usual occupation: Sizing Dept.
11. Industry or business: Celanese Corp.
FATHER 12. Name: Bernard Cecil
13. Birthplace: Md.
MOTHER 14. Maiden name: Mary V. Hite
15. Birthplace: Md.
16. Informant: Bernard Cecil
Address: Cresaptown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24 '39 (month) (day) (year)
Cemetery or crematory: Peoples Cem.
Location: Cresaptown, Md.
18. Funeral director: Louis Stein Inc.
Address: Cumberland.
19. Dec. 23 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21st., 1939, at 5.55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——, 19—, to ——, 19—, and that I last saw h— alive on ——, 19—.

	DURATION
Immediate cause of death: Fractured skull	Instantly killed
Due to	
Due to	
Other conditions: fractured right tibia, upper third.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 12/21/39
Where did injury occur? Cumberland, Allegany, Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Highway
Means of injury: struck by automobile Injured at work? no

23. SIGNATURE: Pierce H. Brown M.D.
M. D. or other
Address: Cumberland, Maryland. Date signed: 12/23/39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(94E)

11613

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Leo Connell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Bahen

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 24 1882

8. AGE: Years	Months	Days	If less than one day
57	9	19	____ hrs. ____ min.

9. Birthplace Cumberland, Allegany, Md. (Town, county, and state)

10. Usual occupation Postmaster

11. Industry or business Post Office

FATHER 12. Name Thomas Connell

13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Mary Murray

15. Birthplace Cumberland, Md.

16. Informant Mrs Anna Connell

Address Westernport, Md.

17. Burial, cremation, or removal. Which?) Cumberland Md Date thereof Dec. 18 '39 (month) (day) (year)

Cemetery or crematory St Patrick Cem

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19 Dec. 16 1939 (Date rec'd by registrar) A Baynhaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1939, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1939, to Dec 15 1939, and that I last saw h— alive on Dec 15th 1939

Immediate cause of death	DURATION
Coronary Thrombosis	12-14-39
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? No (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L W Reeves M. D. or other

Address Westernport Md Date signed 12/16/39

RECEIVED
JAN 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

11614

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 643 Elm St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 643 Elm St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Michael Joseph Craddock

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name ~~of husband~~ or wife Anna W. Shober

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1876

8. AGE: Years	Months	Days	If less than one day
63	3	1	hrs. min.

9. Birthplace Cumberland, Md
(Town, county, and state)

10. Usual occupation Real Estate

11. Industry or business

FATHER 12. Name John W Craddock

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Ann Malamphy

15. Birthplace Maryland

16. Informant Anna W Craddock

Address 643 Elm St. Cumb Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2 1940 (month) (day) (year)

Cemetery or crematory St. Peter & Paul Cemy

Location Cumberland Md

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Dec. 30, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1939, at 11:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14, 1939, to Dec. 29, 1939, and that I last saw him alive on Dec. 29, 1939

Immediate cause of death	DURATION
Coronary Occlusion	1 day
Due to	
Due to	
Other conditions Lobar pneumonia	1 mo.
Hypertrophic arthritis	Indefi nite

(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. W. Mosher M.D.
M. D. or other

Address Cumberland, Md. Date signed 12-30-39

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

11615

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 111 Weber Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 111 Weber Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Rosalee Davis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Stephen S. Davis
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1862

8. AGE: Years 77 | Months 7 | Days 28 | If less than one day: hrs. min.

9. Birthplace: Harrisonburg, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: ######## ??? Dye
13. Birthplace: Virginia

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: John E. Sheetz, Sr.
Address: 111 Weber St., Cumb'd., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 11, 1939 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19 Dec. 8, 39 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7 1939, at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1938, to Dec 7 1939, and that I last saw h[illegible] alive on Dec 7 1939.

Immediate cause of death: Carcinoma of Stomach — DURATION: about 24 yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M. R. Owens M. D. or other
Address: 133 Valley Ave. Date signed: 12-8-39

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94f)

CERTIFICATE OF DEATH

11616

Reg. Dist. No. 6

1. PLACE OF DEATH:
County Allegany
City or town Near Mc Coole (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Gen. Del. Keyser, W. Va.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rural Near Mc Coole Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. Near 21st. Bridge (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Davy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Rosalie Shears Davy
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24th. 1881

8. AGE: Years	Months	Days	If less than one day
58	6	10	hrs. min.

9. Birthplace Hampshire Co. W. Va. (Town, county, and state)
10. Usual occupation Trackman
11. Industry or business B and O. Railroad
FATHER 12. Name George Davy
13. Birthplace Unknown
MOTHER 14. Maiden name Susan Corban
15. Birthplace Unknown
16. Informant George Thomas Davy
Address Gen. Del. Keyser, W. Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1939 (month) (day) (year)
Cemetery or crematory Old Pine Church
Location Purgittsville, W. Va.
18. Funeral director N. H. Rogers
Address Keyser, W. Va.
19. Dec. V 1939 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4th 1939, at 1.20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4, 1939, to Dec 4, 1939, and that I last saw him alive on Dec 4, 1939.

Immediate cause of death	DURATION
Coronary Thrombosis	1 Min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations None Done
Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm F McFarland M. D. or other
Address Keyser, W. Va. Date signed 12/5/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11617

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hosp.

Stay in hospital or inst. (yrs., or mos., or days): STILL BIRTH

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. VA. County:

City or town: BAIRD Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: No Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: DEL SIGNORE, BABY GIRL

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
FEMALE	W.	SINGLE

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 4, 1939

8. AGE: Years	Months	Days	If less than one day
Still Born		ONE	hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Mr. Mike Del Signore
13. Birthplace: Italy

MOTHER — 14. Maiden name: Agnes Del Signore
15. Birthplace: Italy

16. Informant:

Address:

17. (Burial, cremation, or removal. Which?) Memorial Hospital Date thereof Dec 4/39. (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director:

Address:

19. Dec 11, 1939 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 4 1939 7 0/0 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4/39 19 to Dec 4 19 39 and that I last saw h[illegible] alive on Dec 4/39 19

Immediate cause of death	DURATION
Extra Uterine Asphyxia Premature	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: injured at work?

23. SIGNATURE: Dwight Reynolds M.D. M. D. or other

Address: City Date signed: Dec 8/39

RECEIVED
JAN 6 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11618

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Long

(If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution: Near Cumberland

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Long Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. ---

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME David K. Dietz

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna M. Morgan

6(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) ??? Unknown, 1861

8. AGE: Years 78 | Months | Days | If less than one day ---hrs. ---min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business ---

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Mr. Earl Dietz

Address Long, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 21, 1939 (month) (day) (year)

Cemetery or crematory Pleasant Valley Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Dec. 21, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1939, at 7P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16, 1939 to Dec. 18, 1939 and that I last saw him alive on Dec. 16, 1939.

Immediate cause of death	DURATION
Bronchopneumonia	12/12/39
Due to Chronic Myocarditis	1938
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

20 operations

20 autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay K. Turner M. D. or other

Address Cumberland, Md. Date signed 12/21/39

RECEIVED
JAN 6 1940
V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-P)

11619

CERTIFICATE OF DEATH

Reg. Dist. No. 2

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Allegany
City or town: Flintstone
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 30 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Flintstone Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Virginia Lydia Dolley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	married

6 (b) Name of husband or wife: Josiah Dolley
6(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): August 15, 1866

8. AGE:

Years	Months	Days	If less than one day
73	3	17	— hrs. — min.

9. Birthplace: Rudleton County, W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home
FATHER 12. Name: Simeon Mallow
13. Birthplace: Virginia
MOTHER 14. Maiden name: Anna Mallow
15. Birthplace: Virginia
16. Informant: Guy V. Dolly
Address: Fairfield Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4. 1939 (month) (day) (year)
Cemetery or crematory: Glen Dale
Location: Flintstone, Md.
18. Funeral director: Ephraim Smith
Address: Artemas, Pa.
19. Dec 3rd 1939 (Date rec'd by registrar) D. T. Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 2 1939, 1.45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9 1939, to Dec. 2 1939, and that I last saw her alive on Dec 1 1939.

Immediate cause of death	DURATION
Cardiac asthma	30 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. A. Watson M. D. or other
Address: Little Orleans Md. Date signed: Dec. 3. 1939

RECEIVED
JAN 3 1949
BUREAU P. R.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Owens 11620

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 332 Davidson St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 332 Davidson St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Harriet Ann Finley

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John T. Finley

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 30, 1864

8. AGE: Years: 75 Months: 5 Days: 23 If less than one day ____ hrs. ____ min.

9. Birthplace: Cresaptown, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Frederick Starkey
13. Birthplace: Virginia

MOTHER
14. Maiden name: Susan Oats
15. Birthplace: Virginia

16. Informant: Mrs Ed. Smith

Address: 332 Davidson St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26, 1939 (month) (day) (year)

Cemetery or crematory: Porter Cemetery

Location: Eckhart, Md.

18. Funeral director: John C. Wolford

Address: Cumberland, Md.

19. Dec. 23, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 23, 1939, at 8:04 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 1939, to Dec 23 1939, and that I last saw her alive on Dec 23 1939.

Immediate cause of death: Arterio Sclerosis — DURATION: about 2 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): no

Means of injury Injured at work?

23. SIGNATURE: M E B Owens M. D. or other

Address: 33 Va ave Date signed: 2/24/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93C)

11621

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 507 Patterson Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 507 Patterson Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME Sebastian Fleckenstein

3. (b) Social Security Number none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Louise B.

6(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) August 7 - 1868

8. AGE: Years 71 Months 4 Days 2 If less than one day ___ hrs. ___ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Boat Builder

FATHER 12. Name Sebastian Fleckenstein

13. Birthplace Germany

MOTHER 14. Maiden name Elizabeth Glemink

15. Birthplace Germany

16. Informant Mrs Henry Reuhl

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 11-39 (month) (day) (year)

Cemetery or crematory St Peter & Paul's

Location Cumberland Md.

18. Funeral director V. L. Lemperour

Address Cumberland, Md

19 Dec. 11, 1939 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9 1939, at 9:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/28 1939 to 12/9 1939, and that I last saw him alive on 12/8 1939.

Immediate cause of death Cerebral hemorrhage — DURATION 10 Da

Due to Arteriosclerosis Fatal

Due to

Other conditions Chronic myocarditis.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. W. McLeod M.D. M. D. or other

Address Cumberland Md Date signed 12/11/39

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

11622

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 403 Vine St

Stay in hospital or inst. (yrs., or mos., or days): 6 Yrs

Stay in this community (yrs., or mos., or days): 5 Yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 403 Vine St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Benjamin Cleveland Franklin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Marie S. Franklin

6(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Dec. 2. 1875

8. AGE:

Years	Months	Days	If less than one day
64		5	hrs. min.

9. Birthplace: Westernport Allegany Md.

(Town, county, and state)

10. Usual occupation: Maintenance Of Way.

11. Industry or business: Railroad

FATHER

12. Name: Henry Franklin

13. Birthplace: England.

MOTHER

14. Maiden name: Mary Jane Morrison

15. Birthplace: Baltimore, Md.

16. Informant: Marie S. Franklin

Address: 403 Vine St. Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 10, 1939 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: David S. Boal

Address: Westernport, Md.

19. Dec. 10 1939 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 1. 1939, at 3:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1939, to Dec 7 1939, and that I last saw h— alive on Dec 7 do 1939

Immediate cause of death	DURATION
Cardiovascular renal disease	?
Due to	
Due to	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L W Reeves M D

M. D. or other

Address: Westernport Md. Date signed: 12/8/39

RECEIVED
JAN 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-a)

CERTIFICATE OF DEATH

11623 ✓

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 Days 2 hrs 50 min

Stay in this community (yrs., or mos., or days): 2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County: Garrett

City or town: Avilton Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Hilda Rose Garlitz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): December 17, 1939

8. AGE:

Years	Months	Days	If less than one day
		2	2 hrs. 50 min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Lemuel A. Garlitz

13. Birthplace: Avilton, Maryland

MOTHER — 14. Maiden name: Rose A. Garlitz

15. Birthplace: Deal, Pennsylvania

16. Informant: Mrs. Lemuel A. Garlitz

Address: Avilton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 19, 1939 (month) (day) (year)

Cemetery or crematory: St. Agnes, Cem

Location: Avilton, Md

18. Funeral director: Lemuel A. Garlitz, father

Address: Avilton, Md

19. Dec. 19, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19th 1939 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from at birth 19 to Dec 19 1939, and that I last saw h-- alive on Dec 18th 1939.

	DURATION
Immediate cause of death: Hydrocephalus & Spina bifida	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: R. C. Bowers M.D.
M. D. or other

Address: Cumberland, Md Date signed 12-19-39

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

11624

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 163 N. Center St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Ida Gottlieb

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: David Gottlieb
6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 13, 1880

8. AGE: Years: 59 | Months: 6 | Days: 27 | If less than one day: hrs. min.

8. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: Jacob Loeb
13. Birthplace: Germany

MOTHER
14. Maiden name: Esther Mayer
15. Birthplace: Germany

16. Informant: Mr. Jacob Gottlieb
Address: 167 N. Centre St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 12, 1939 (month) (day) (year)
Cemetery or crematory: Hebrew Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Dec. 11 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10, 1939, at 10 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-28-39 19 to 12-10-39 19, and that I last saw h alive on 12-9-39 19.

	DURATION
Immediate cause of death: Bronchio Pneumonia	12 days
Due to:	
Due to:	
Other conditions: Diabetes Mellitus	2

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Zimmerman M. D. or other
Address: Date signed

Dr Zimmerman

RECEIVED
JAN 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (118)

CERTIFICATE OF DEATH

11625

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hosp

Stay in hospital or inst. (yrs., or mos., or days): 5 days

Stay in this community (yrs., or mos., or days): 30 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 55 Boone (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs Adeline V. Hartsock

3. (b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter Hartsock

6(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Jan 27 1889

8. AGE: Years: 50 Months: 11 Days: 2 If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER 12. Name: Peter Morrison

13. Birthplace: Md

MOTHER 14. Maiden name: Agnes McKenzie

15. Birthplace: Md

16. Informant: Walter Hartsock

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 2-40 (month) (day) (year)

Cemetery or crematory: St Patricks Cem

Location: Cumberland, Md.

18. Funeral director: V. L. Lemperans

Address: Cumberland, Md.

19. Jan 2, 1940 (Date rec'd by registrar) J. P. Franklin, N. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 29 1939, at 12:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 1939, to Dec 29 1939, and that I last saw her alive on Dec 29 1939.

Immediate cause of death: Gastric Hemorrhage — DURATION: 3 days

Not due to ulcer; not due to cancer.

Due to: Gastric Varicose

The gastric hemorrhage was due to the gastric varices. CWGR.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: R. C. Bowen M.D. (M. D. or other)

Address: Cumberland Md Date signed: 12-29-39

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (948)

CERTIFICATE OF DEATH

11626

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 722 Hilltop Drive
Stay in hospital or inst. (yrs., or mos., or days): 66 years
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 722 Hilltop Drive
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George Wesley Hoff

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8 (b) Name of husband or wife: Anna Baker
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 26, 1873

8. AGE: Years: 66 Months: 5 Days: 13 If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Conductor

11. Industry or business: B. & O. Railroad

FATHER — 12. Name: Andrew Hoff
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Unknown
15. Birthplace:

16. Informant: Russell Hoff
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 12, 1939 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Dec. 11, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr Durrett

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1939, at 12 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9, 1939 to Dec. 9, 1939, and that I last saw him alive on Dec. 1939.

Immediate cause of death	DURATION
Coronary Thrombosis (Duration 1 hr.)	12/9/39
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Clay E. Durrett M. D. or other
Address: Cumberland, Md. Date signed Dec 11, 1939

RECEIVED
JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (210-m)

CERTIFICATE OF DEATH

11627

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Near Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 35 yrs 4 mos 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Barton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ✓
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Emmett Lee Howell

3. (b) Social Security Number: 216-09-2977

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Florence Turnbull

6(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): August 4, 1904

8. AGE:

Years	Months	Days	If less than one day
35	4	12	____ hrs. ____ min.

9. Birthplace: Barton, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Mine

FATHER
12. Name: Charles Howell
13. Birthplace: Barton, Md

MOTHER
14. Maiden name: Mary A. Logan
15. Birthplace: Barton, Md.

16. Informant: Edna G. Howell

Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 19, 1939 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Meadow, Md.

18. Funeral director: (C.) Eichhorn

Address: Lonaconing, Md.

19. 12-19-1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16th., 1939, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Compound, comminuted fracture of skull.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: no autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 12/16/1939

Where did injury occur? Near Cumberland, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Highway #40

Means of injury: Auto collision Injured at work? no

23. SIGNATURE: Chas. H. Bowen, M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 12/16/39

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11628

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 days

Stay in this community (yrs., or mos., or days): 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Bedford

City or town: Hyndman Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mabel Imler

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Alfred

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 9, 1914

8. AGE:

Years	Months	Days	If less than one day
25	6	22	____ hrs. ____ min.

9. Birthplace: Hyndman, Bedford, Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Harry Imler

13. Birthplace: Hyndman, Pa.

MOTHER

14. Maiden name: Gillian Boorbaugh

15. Birthplace: Hyndman, Pa. R.D.I.

16. Informant: Alfred T. Imler

Address: Hyndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 5 1939 (month) (day) (year)

Cemetery or crematory: Hyndman Cemetery

Location: Hyndman, Pa.

18. Funeral director: Harvey A. Zeigler

Address: Hyndman, Penna.

19. Dec. 5 (Date rec'd by registrar) 1939 J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 1939, at 2:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 30 1939, to Dec. 2 1939, and that I last saw her alive on Dec. 2 1939

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to Cellulitis of face	?
Due to	
Other conditions Septicemia	4 days

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W R Hodges, Jr. M.D.

Address: Cumberland, Md M. D. or other

Date signed 12/2/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

11629

Reg. Dist. No. ____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Burtow
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or Inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 75 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Barton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Othe G Snakeep

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife: Sarah Snakeep
6(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Feb. 1, 1864

8. AGE: Years: 75 | Months: 10 | Days: 18 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Barton, Allegany, Md. (Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mine
FATHER 12. Name: Joseph Snakeep
13. Birthplace: Virginia
MOTHER 14. Maiden name: Mary Dawson
15. Birthplace: Maryland
16. Informant: Hazel Snakeep
Address: Barton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21, 1939 (month) (day) (year)
Cemetery or crematory: Shilos Cem.
Location: Westernport
18. Funeral director: D. S. Boor
Address: Barton, Md.
19. Dec 20 1939 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19th 1939 at 9:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1939 to Dec 19 1939 and that I last saw h[illegible] alive on Dec 19 1939

Immediate cause of death	DURATION
Uremia	5 days
Due to Chronic Nephritis	14 Y
Due to Chronic Myocarditis	14 Y
Due to	
Other conditions Arteriosclerosis	2 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ✓
Of autopsy: ✓

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Raymond W Reese M. D. or other
Address: Westernport Md. Date signed 12.20.39

RECEIVED
JAN 5 1948
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11630

(186a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 406 Fayette St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 406 Fayette St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Keller

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ Henry Keller

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1849

8. AGE: Years 90 Months 2 Days 2 If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Conrad Zimmerman
13. Birthplace Germany

MOTHER
14. Maiden name Mary Ann Nebb
15. Birthplace Germany

16. Informant William L. Keller

Address 406 Fayette St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31 1939 (month) (day) (year)

Cemetery or crematory Rose Hill cemetery

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland Md

19. Dec 30 39 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1939, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1939, to Dec 29 1939, and that I last saw her alive on Dec 28 1939.

Immediate cause of death Hypostatic Pneumonia Senility & Exhaustion

DURATION

Due to Fracture of Hip: Due to an accidental fall, in her home. N.W.G.R. 4 mos.

Due to Hooked her toe under edge of a rug, while walking in her room.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 17th 1939.

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) in her home.

Means of injury Accidental fall. Injured at work?

23. SIGNATURE R. C. Bowen M.D.
M. D. or other

Address Cumberland Md Date signed 12-30-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Bowen

RECEIVED
JAN 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

11631

1. PLACE OF DEATH

County Allegany Registration Dist. No. 6

Village or City Westernport, Md. No. The Reeves Clinic St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

WITHIN CORPORATE LIMITS OF

Length of residence in city or town where death occurred ..... yrs. ..... mos. 16 ds. How long in U.S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Homer B. Keplinger If U. S. Veteran, specify WAR

(a) Residence: No. (P.O.) Ridgeville, W.Va. St., Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Effie Berg.

6. DATE OF BIRTH (month, day, and year): July 19, 1884

7. AGE: Years 55 | Months 5 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Carpenter

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.:

10. Date deceased last worked at this occupation (month and year): Dec. 9, 1939

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Lehmansville W.Va.

FATHER

13. NAME: B.F. Keplinger

14. BIRTHPLACE (city or town) (State or country): W.Va.

MOTHER

15. MAIDEN NAME: Anna Berg.

16. BIRTHPLACE (city or town) (State or country): W.Va.

17. INFORMANT (Address): Mrs. Effie Keplinger Riggeville, W.Va.

18. BURIAL, CREMATION, OR REMOVAL
Place: Lehmansville, W.Va. Date: Dec. 29, 1939

19. UNDERTAKER (Address): THURSH'S ROMNEY, W.VA.

20. FILED Dec. 29, 1939 A.J. Saxenbaker M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Dec. 26, 1939 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1939, to Dec. 26, 1939

I last saw him alive on Dec. 26, 1939; death is said to have occurred on the date stated above, at 7:45P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Septicaemia: primary cause of the septicemia: not known. C.W.S.R. Not due to accident or injury.	?

Other Contributory Causes of importance: Duration: not known.

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) [signature] M. D.

(Address) Westernport, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120)

CERTIFICATE OF DEATH

11632

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 hr.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Oakland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Rt.#1, Box 119
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Herbert King

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: None

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 15, 1924

8. AGE: Years	Months	Days	If less than one day
15	0	17	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER 12. Name: Abe King

13. Birthplace: Maryland

MOTHER 14. Maiden name: Alice McCloud

15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4-1939 (month) (day) (year)

Cemetery or crematory: King Cemetery

Location: Mt Lake Park

18. Funeral director: Emery Boldin

Address: Oakland md

19. Dec. 2 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. W. A. VAN ORMER

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2, 1939, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-2-39 19 to 12-2-39 19, and that I last saw him alive on 12-2-39 19.

Immediate cause of death	DURATION
Diagnosis not made	
Due to: Gastroenteritis. cause?	
Due to: Note. Child only lived 1 hour after coming to hospital & not sufficient time to make diagnosis	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Alfred VanOrmer, M. D. or other

Address: Cumberland, Md. Date signed 12-2-39

RECEIVED
JAN 6 1949
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

#8076 11633

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 202 So. Mechanic St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 202 So. Mechanic (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William A. King

3. (b) Social Security Number

4. Sex: Male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Etta O. King

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec 6 - 1873

8. AGE: Years 66 Months – Days – If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Baggageman (Retired)

11. Industry or business: W. Md. R.R. Co

FATHER

12. Name: John C King

13. Birthplace: Md

MOTHER

14. Maiden name: Laura L. Cook

15. Birthplace: Md

16. Informant: Wilbur King

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 10 - 39 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland Md

18. Funeral director: V. L. Lemperour

Address: Cumberland Md.

19 Dec 9, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6th., 1939 about 5.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Cerebral hemorrhage

DURATION

Due to

Due to

Other conditions: Chronic myocarditis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Lennes H. Larson, M. D. M. D. or other

Address: Cumberland, Maryland Date signed: 12/9/39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46B)

WITHIN CORPORATE LIMITS 11634

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 164 Lee St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 39 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 164 Lee St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George Washington Kyle

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Jeanetta McIntyre Kyle

6(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): June 12 1845

8. AGE: Years: 84 Months: 6 Days: 7 If less than one day: hrs. min.

9. Birthplace: Hardy Co. W. Va. (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER — 12. Name: William Kyle

FATHER — 13. Birthplace: Hardy Co, W. Va.

MOTHER — 14. Maiden name: Lettie Snyder

MOTHER — 15. Birthplace: Virginia

16. Informant: John. Tyler.

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 21, 1939 (month) (day) (year)

Cemetery or crematory: Allegany Cem.

Location: Frostburg Md.

18. Funeral director: D. S. Bokel

Address: Barton, Md.

19. Dec. 19 1939 (Date rec'd by registrar) Mio. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9th 1939, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 1939, to Dec 19 1939, and that I last saw him alive on Dec 9 1939.

Immediate cause of death	DURATION
Carcinoma of Stomach	? ?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane Jr. M.D. M. D. or other

Address: Frostburg Md. Date signed: Dec 19 39

Authorization to change year of birth see letter filed under McLane in permanent file. 2/6/40.

RECEIVED
JAN 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 215-m

CERTIFICATE OF DEATH

11635 9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital Frostburg

Stay in hospital or inst. (yrs., or mos., or days): 1 mo 7 days

Stay in this community (yrs., or mos., or days): 1 " 7 "

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ohio County:

City or town: Toledo Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 3408 Glynn Drive
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME Magdalene Laney

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles E. Laney

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 23 - 1869

8. AGE: Years: 70 Months: 3 Days: 6 If less than one day: hrs. min.

9. Birthplace: Toledo Ohio
(Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business:

FATHER
12. Name: Joseph Zahnle
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: " "

16. Informant: Colette Laney
Address: Toledo Ohio

17. Removable (Burial, cremation, or removal. Which?) Date thereof Dec 29 - 1939 (month) (day) (year)

Cemetery or crematory: Cemetary

Location: Toledo Ohio

18. Funeral director: J. J. Kunst

Address: Frostburg Md

19. 12-29 (Date rec'd by registrar) 19 39 mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1939, at 1 20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/24/39 19 to 12/29/39 19, and that I last saw h ER alive on 12/28/39 19

	DURATION
Immediate cause of death: Cardiac & respiratory failure	
Due to: Apoplexia (Cerebral)	
Due to: Injuries received in auto accident	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide~~ homicide: Date of 11/22/39

Where did injury occur? Frostburg (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Auto accident Injured at work?

23. SIGNATURE: John Kilday M.D.
M. D. or other

Address: 56 W. Main St. Date signed 12/29/39

RECEIVED
JAN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11636 9

Reg. Dist. No. 1

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 18 Blair St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 18 Blair St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Wm Henry Lemmert

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Sarah Lemmert

6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 10 1870

8. AGE: Years: 69 | Months: 7 | Days: 17 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Retired Policeman

11. Industry or business:

FATHER — 12. Name: Henry Lemmert

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Germany

16. Informant: Wm Lemmert Jr.

Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 27-39 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Duerst

Address: Frostburg Md.

19. 12-27 1939 (Date rec'd by registrar) Mrs. A. R. Weller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 1939, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 24 1939 to Dec 24 1939 and that I last saw him alive on Dec 24 1939

Immediate cause of death	DURATION
Angina Pectoris	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W O M Lane Jr M.D. M. D. or other

Address: Frostburg Md Date signed: Dec 27 '39

RECEIVED
JAN 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

11637

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Frostburg Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 125 E. Main St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 38 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 125 E. Main St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Bertha Indiana Davis Long

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Clarence L. Long

6(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 2, 1877.

8. AGE: Years 62 | Months 6 | Days 7 | If less than one day ___ hrs. ___ min.

9. Birthplace Vale Summit, Allegany, Md. (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Clothing Store.

FATHER

12. Name Alexander Davis

13. Birthplace Vale Summit, Md

MOTHER

14. Maiden name Mary Ellen Loar

15. Birthplace Loartown Md

16. Informant Clarence Long.

Address 125 E. Main St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 12, 1939. (month) (day) (year)

Cemetery or crematory Allegany Cem.

Location Frostburg Md.

18. Funeral director Jacob Hofer.

Address Frostburg Md.

19. Dec 11, 1939 (Date rec'd by registrar) J. S. Franklin, M.D. Registrar

Mrs. A. R. Nalle Registrar

Dr. Murray -

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1939, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1939, to Dec 9 1939, and that I last saw her alive on Dec 6 1939.

Immediate cause of death	DURATION
Acute Dilatation of Heart	15 min
Myocarditis & Endocarditis	10 yrs
Due to Primary carcinoma of stomach. C.W.G.R.	
Due to	
Other conditions Carcinoma R lung	6 mos
& Pyloric end of stomach	"

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. Alan G. [illegible] M.D. or other

Address 41 Emm St Date signed Dec 11

[illegible] 39

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 9 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-6)

11640

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 843 Braddock Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 843 Braddock Road.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry Wellington Matheney

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

B (b) Name of husband or wife Gertrude Sincell

B(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) April 18, 1882

8. AGE: Years 57 Months 7 Days 16 If less than one day ___ hrs. ___ min.

9. Birthplace Lonaconing, Allegany, Md.
(Town, county, and state)

10. Usual occupation Druggist

11. Industry or business Drug Store

FATHER
12. Name Robert Matheney
13. Birthplace Sheperdstown W. Va.

MOTHER
14. Maiden name Mary E. Russell
15. Birthplace Harpers Ferry, W. Va.

16. Informant Wm Matheney

Address Allegany Co. Home - Cumberland

17. Burial Date thereof Dec 7, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakland Cemetery

Location Oakland Md

18. Funeral director Jacob Hafer

Address Cumberland Md.

19. Dec. 6, 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4- 1939, at 8:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-3- 1939, to 12-4- 1939, and that I last saw him alive on 12-4- 1939.

Immediate cause of death "Complete heart block." DURATION 24 hrs.

Due to Coronary artery

Due to disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 12/6/39

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

CERTIFICATE OF DEATH

11638

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 104 Futtman Highway

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 104 Futtman Highway
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Smyth Mc Donald

3. (b) Social Security Number 214-05-4087

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Dena Mc Donald

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1882

8. AGE: Years	Months	Days	If less than one day
57	11	5	____ hrs. ____ min.

9. Birthplace Frostburg, Md
(Town, county, and state)

10. Usual occupation Cashier - at Bank

11. Industry or business Peoples Bank

FATHER 12. Name Alexander Smyth

FATHER 13. Birthplace England

MOTHER 14. Maiden name Elizabeth Davis

MOTHER 15. Birthplace England

16. Informant Dena Mc Donald

Address 104 Futtman Highway

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31, 1939 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Dec. 30 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1939, at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/15/38 1939 to 12/29 1939, and that I last saw him alive on 12/28/39 1939

Immediate cause of death	DURATION
Coronary thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K. Rozum M.D.
M. D. or other

Address Cumberland Md Date signed 12/30/39

RECEIVED
JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

11639

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 323 Maryland Ave.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 323 Maryland Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Morgan Camel McIlwee

3. (b) Social Security Number: 705-09-7299

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	White	Widower

6 (b) Name of husband or wife: Blanche R. McIlwee (Deceased)

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 11, 1882

8. AGE: Years	Months	Days	If less than one day
57	4	9	hrs. min.

9. Birthplace: Romney, W. Va. (Town, county, and state)

10. Usual occupation: Car Repairman

11. Industry or business: B. & O. Ry. Co.

FATHER

12. Name: John D. McIlwee

13. Birthplace: Romney, W. Va.

MOTHER

14. Maiden name: Margaret Smith

15. Birthplace: Moorefield, W. Va.

16. Informant: Mrs. Robt. T. Youst

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23/39 (month) (day) (year)

Cemetery or crematory: Agusta

Location: Agusta, W. Va.

18. Funeral director: E. M. Tandy, Em Tandy

Address: Keyser, W. Va.

19. Dec. 22 1939 (Date rec'd by registrar) A. J. Saynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20 1939, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16, 1939, to Dec. 20 1939, and that I last saw him alive on Dec. 20, 1939.

Immediate cause of death	DURATION
Circulatory failure	
Due to Chronic myocarditis and myocardial degeneration.	6 yrs.
Due to Arteriosclerosis	6-8 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James H. Wolverton, Jr. M.D. M.D. or other

Address: Piedmont W. Va. Date signed: 12/22/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11641

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 809 Kentucky Avenue

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 809 Kentucky Avenue

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Stillborn Miller — Infant Miller

3. (b) Social Security Number

4. Sex: Female

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1939

8. AGE: Years | Months | Days | If less than one day ____ hrs. 0 min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: --

11. Industry or business

FATHER
12. Name: Charles Woods
13. Birthplace: ~~Maryland~~ (?)

MOTHER
14. Maiden name: Mary Miller
15. Birthplace: Cumberland, Maryland

16. Informant: ~~Mr~~ Mary Miller
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 23, 1939 (month) (day) (year)

Cemetery or crematory: Allegany County Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Dec. 23 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 1939, at 5a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1939, to Dec 23 1939, and that I last saw her alive on Dec 18 1939.

Immediate cause of death: Stillbirth, asphyxiation during birth

Due to: Breech case

Due to: not being delivered rapidly enough

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 20 mo

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: F. Alan G. Newman, M.D. M.D. or other

Address: 41 Green St. Cumberland — Date signed: Dec 23 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

CERTIFICATE OF DEATH

11642

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 64 Greene Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 63 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: 64 Greene Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 64 Greene Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Albert Lewis Miller

Albert Lewis Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Mzrried

6 (b) Name of husband or wife: Anna B. Martz

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3, 1876

8. AGE: Years: 63 Months: 6 Days: 28 If less than one day: hrs. min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Dairy products

FATHER — 12. Name: Albert Lewis Miller

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Margaret Ann Healey

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Anna Martz Miller

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3, 1940 (month) (day) (year)

Cemetery or crematory: St. Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Jan. 2 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31-1939, at 11:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-31-1939 to 12-31-1939 and that I last saw h~~im~~ alive on 12-31-1939.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4hrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address: Cumberland Date signed 1-2-40.

RECEIVED
JAN 6 19
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

11643

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH.

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 202 So Mechanic St

Stay in hospital or inst. (yrs., or mos., or days): 30 yrs.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 202 S. Mechanic St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William J. Moran

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

8 (b) Name of husband or wife: Ruth Lewis Moran

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 25 1882

8. AGE: Years: 57 Months: 7 Days: 26 If less than one day: hrs. min.

9. Birthplace: Illinois (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: General

FATHER 12. Name: Harry J. Moran

FATHER 13. Birthplace: Ill.

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: "

16. Informant: Mrs Ruth L Moran

Address: Cumberland md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec 24 1939 (month) (day) (year)

Cemetery or crematory: Hillcrest Mem. Park

Location: Cumberland Md

18. Funeral director: Louis Stein Sons

Address: Cumberland md

19. Dec 23 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 1939, to Dec 21 1939, and that I last saw h[illegible] alive on Dec 20 1939.

Immediate cause of death	DURATION
Disseminated Sclerosis	2 yrs
Due to	
Due to	
Other conditions Terminal Bulbar Paralysis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. C. Bowen M.D. M. D. or other

Address Cumberland Date signed 12-21-39

RECEIVED
JAN 8 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-b)

11644

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Spring Gap, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Rawlings, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Josephine Ullum Moreland

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Francis M. Moreland

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1855

8. AGE: Years 84 Months 3 Days 12 If less than one day hrs. min.

9. Birthplace Dans Run, Mineral Co., W. Va.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business At Home.

FATHER
12. Name John Ullum
13. Birthplace Dans Run W. Va.

MOTHER
14. Maiden name Susan Ward
15. Birthplace Dans Run W. Va.

16. Informant S. M. Piper
Address Spring Gap, Md.

17. Burial Date thereof Dec 12, 1939.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md

18. Funeral director Jacob Hafer
Address Cumberland, Md.

19. Dec. 11, 1939 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

Dr Koon

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 1939, to Dec 9 1939, and that I last saw her alive on Dec. 9 1939.

Immediate cause of death Obstruction of bowels. Cause not determined.

Due to Intestinal obstruction Not due to cancer. C.W.G.R.

Due to Duration: 24 hours.

Other conditions old age

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 24 hours

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. N. Koon
M. D. or other

Address Cumberland, Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(I)

RECEIVED
JAN 0 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

CERTIFICATE OF DEATH

11645

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: 410 Columbia St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 25 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 410 Columbia St,

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Andrew Francis Nelson

3. (b) Social Security Number 214-05-6504

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

B (b) Name of husband or wife Marie Hausman

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29, 1882

8. AGE:

Years	Months	Days	If less than one day
57	1	23	hrs. min.

9. Birthplace Eckhart, Allegany, Md.
(Town, county, and state)

10. Usual occupation Barber

11. Industry or business Retail Barber Shop.

FATHER 12. Name Wm. Nelson

13. Birthplace Eckhart Md.

MOTHER 14. Maiden name Margaret Kelley

15. Birthplace Eckhart, Md.

16. Informant Mrs. Andrew Nelson

Address 410 Columbia St. Cumberland

17. Greenmont Burial Date thereof Dec 26, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmont Cem

Location Cumberland, Md

18. Funeral director Jacob Hofer

Address Cumberland, Md.

19 Dec. 23 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Hodges

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1939, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25 1939 to Dec. 22 1939

and that I last saw him alive on Dec. 21 1939

Immediate cause of death:	DURATION
Mediastinal Lymphoblastoma	
Due to	
Pleural Effusion	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W R Hodges, M.D.

M. D. or other

Address Cumberland, Md. Date signed 12/24/39

RECEIVED
JAN 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-a)

CERTIFICATE OF DEATH

11646

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 days

Stay in this community (yrs., or mos., or days): 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Hampshire

City or town: Augusta Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Edna Eleanor Pancione

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~: Zopito Pancione

6(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): April 9, 1907

8. AGE: Years	Months	Days	If less than one day
32	7	22	hrs. min.

9. Birthplace: Fairfax, Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home work

FATHER — 12. Name: Harry C. Mentzer

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Lillian Mathews

15. Birthplace: Fairfax, Virginia

16. Informant: Mrs. Geo. Stewart

Address: Augusta, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 5, 1939 (month) (day) (year)

Cemetery or crematory: Augusta Cem.

Location: Augusta, W. Va.

18. Funeral director: W. H. McKee

Address: Augusta W Va

19. Dec. 5 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 1939, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1939 to Dec 2 1939, and that I last saw her alive on Dec 2 1939

Immediate cause of death	DURATION
Paralysis of respiration while under Ether anaesthesia (Tonsil operation)	
Due to: Ether Anaesthesia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury — Injured at work?

23. SIGNATURE: F. P. O'Neil, M.D. M. D. or other

Address: Cumberland, Md. Date signed: 12/2/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1910
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11647

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town DEER PARK Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME PAUGH, BABY GIRL (Stillborn)

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
FEMALE	WHITE	NEW BORN

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 24 1939

8. AGE:

Years	Months	Days	If less than one day
			hrs. min.

9. Birthplace MARYLAND, Cumberland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name ALLEN PAUGH
13. Birthplace MARYLAND, Deer Park

MOTHER
14. Maiden name OMA BRENNEMAN
15. Birthplace MARYLAND Swanton

16. Informant ALLEN PAUGH
Address DEER PARK, MD.

17. Burial Date thereof Dec 24 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakland Cem

Location Oakland Md

18. Funeral director Emroy Bolden

Address Oakland Md

19. Dec. 24 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

DR. K. REYNOLDS

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 24, 1939 at 4:14 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24/39 19 to Dec 24/39 19, and that I last saw h[illegible] alive on Dec 24/39 19.

Immediate cause of death	DURATION
Intra Uterine asphyxia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Virginia Reynolds M.D.
M. D. or other

Address Cutey Date signed Dec 24/39

RECEIVED
JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-e)

11648

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital.

Stay in hospital or inst. (yrs., or mos., or days) 4 days.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Vale Summit. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Near Frostburg Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Howard Perry

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6 (b) Name of husband or wife Rebecca Robinette

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 21, 1872

8. AGE: Years	Months	Days	If less than one day
67	7	0	____ hrs. ____ min.

9. Birthplace Oldtown Allegany, Md.

(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal Mines.

FATHER 12. Name John Perry

13. Birthplace Virginia

MOTHER 14. Maiden name Jane Butler.

15. Birthplace Unknown.

16. Informant Walter H. Perry.

Address Vale Summit Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24 1939 (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Vale Summit, Md.

18. Funeral director Jacob Hafer.

Address Frostburg, Md.

19. 12-22 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

Cobey

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21. 1939 1939 at 1.09 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3. 1939 to Dec. 21. 1939 and that I last saw h— alive on Dec. 21 1939

Immediate cause of death	DURATION
Chronic myocarditis.	
Uremia.	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. C. Cobey M. D. or other

Address Frostburg Md Date signed 12-22-39

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11649

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3 Altamont Terrace

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn Boy Phillips

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	stillborn

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Stillborn

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Cumberland Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Stewart Phillips

13. Birthplace Fort Stockton Texas

MOTHER 14. Maiden name Pasquita Baldwin

15. Birthplace Philadelphia Pa.

16. Informant Stewart Phillips

Address 3 Altamont Terrace

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan 4, 1940 (month) (day) (year)

Cemetery or crematory Hafer's Crematory

Location Cumberland, Md.

18. Funeral director Jacob Hafer

Address Cumberland

19. Jan. 3, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1939, at 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to Dec. 31 1939

and that I last saw h alive on 19

Immediate cause of death	DURATION
Due to Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Phillips M. D. or other

Address 4 Altamont Date signed Jan 3 1940

Dr Seminales

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

11650

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 128 W. Roy Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 58-11-5

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 128 Roy Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Stanley C. Bruce Pressman

3. (b) Social Security Number: 220-10-2121

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lena Schramm Pressman
6(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): Jan. 20, 1881
8. AGE: Years 58 Months 11 Days 5 If less than one day ___ hrs. ___ min.
9. Birthplace: Frostburg, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: N.P.G.
11. Industry or business: Government
FATHER
12. Name: Peter Pressman
13. Birthplace: Frostburg, Md.
MOTHER
14. Maiden name: Mary Ann Woskman
15. Birthplace: Frostburg, Md.
16. Informant: Mrs. Leona Ward
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 28 1939 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: M. Eichhorn
Address: Lonacoming, Md.
19. 12-28 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25 1939, at 8 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 1939, to Dec 25 1939, and that I last saw him alive on Dec. 25 1939.
Immediate cause of death: Cardiac dilatation
Due to
Due to
Other conditions: Asthma
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. C. Coley M. D. or other
Address: Frostburg, Md. Date signed: 12-28-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11651

Reg. Dist. No. 14

1. PLACE OF DEATH:
County Allegany
City or town Ellerslie Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Ellerslie Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mr. Virgel E. Printy

3. (b) Social Security Number

4. Sex M.
5. Color or race W.
6. (a) Single, married, widowed, or divorced Married
6 (b) ~~Name of husband or wife~~ Cathern, Barnard
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 17 1901.
8. AGE: Years 38 Months 9 Days 17 If less than one day hrs. min.
9. Birthplace Ellerslie Md.
(Town, county, and state)
10. Usual occupation Labor.
11. Industry or business
FATHER 12. Name Walter Printy
13. Birthplace Md.
MOTHER 14. Maiden name Emma (Lowery)
15. Birthplace Md.
16. Informant Mr. Walter Printy
Address Ellerslie Md.
17. Burial Date thereof Dec 3, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Porter
Location Near Ellerslie Md.
18. Funeral director Harvey H. Zeigler
Address Hyndman Pa.
19. Dec 3 1939 J. Lloyd Wolfe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1939, at 5A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1938, to Dec. 1st 1939, and that I last saw him alive on November 28 1939.
Immediate cause of death Pulmonary Tuberculosis — DURATION 1 year
Due to
Due to
Other conditions Silicosis — 6 yrs.
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A. Topper M.D.
M. D. or other
Address Hyndman Pa. Date signed Dec 2nd '39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107-01

11652

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 614 Troy St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 10 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 614 Troy St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John W Puhalla

3. (b) Social Security Number

4. Sex male

5. Color or race white

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 17, 1939

8. AGE: Years | Months 10 | Days 9 | If less than one day hrs. min.

9. Birthplace Cumberland, Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name John Puhalla
13. Birthplace Cumberland, Md

MOTHER
14. Maiden name Eva Hutcherson
15. Birthplace West Va.

16. Informant John Puhalla

Address 614 Troy St.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Dec. 28, 1939
(month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address 117 Fredrick St - Cumb - Md.

19 Dec. 28, 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1939, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1939, to Dec 28 1939, and that I last saw him alive on Dec 26 1939.

Immediate cause of death Broncho - Pneumonia

DURATION about 5 days

Due to The Broncho-pneumonia was primary.

Due to There was no associated disease.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) No

Means of injury Injured at work?

23. SIGNATURE M. L. Owens M. D. or other

Address 33 Va Date signed 12-27-39

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 8 1940
BUREAU V. S.

11653

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (210-m)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Va County

City or town Ridgely Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Miller Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James Wm. Ralston

3. (b) Social Security Number 214-07-1739

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Celestia Ralston

6(c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) June 25-1912

8. AGE: Years 27 Months 5 Days 21 If less than one day ___ hrs. ___ min.

9. Birthplace Eckhart, alleg. md. (Town, county, and state)

10. Usual occupation Spinner

11. Industry or business Cleaners plant

FATHER 12. Name Martin L. Ralston

13. Birthplace Md.

MOTHER 14. Maiden name Margret Condon

15. Birthplace Eckhart, Md.

16. Informant Martin Ralston

Address Frostburg Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Dec 19-1939 (month) (day) (year)

Cemetery ~~or crematory~~ St Michaels

Location Frostburg Md

18. Funeral director J J Durst

Address Frostburg Md

19. 12-19 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16th., 1939, at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death Fractured skull — DURATION 3 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy no autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12/16/39

Where did injury occur? Near Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury auto collision Injured at work? no

23. SIGNATURE Linnie H. Corson, M.D. M. D. or other

Address Cumberland, Md. Date signed 12/18/39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 9 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

11654

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1939
68
1871
(M)

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 425 Pennsylvania Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 425 Pennsylvania Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Steele Ralston

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm Ralston

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.): July 13, 1871

8. AGE: Years 68 | Months 6 | Days 16 | If less than one day ___ hrs. ___ min.

9. Birthplace: Barton, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business: At Home

FATHER
12. Name: John Clark
13. Birthplace: Scotland

MOTHER
14. Maiden name: Jennie Watt
15. Birthplace: Scotland

16. Informant: Mrs Janet W. Weaver

Address: 425 Pennsylvania Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31, 1939 (month) (day) (year)

Cemetery or crematory: Oak Hill

Location: Lonaconing, Md

18. Funeral director: Jacob Hafer

Address: Cumberland, Md

19. Dec. 31, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Hodges

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1939, at ___ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1939, to Dec. 29 1939, and that I last saw h___ alive on ___ 19___.

Immediate cause of death: Carcinomatosis

Due to: Carcinoma of Sigmoid

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

DURATION: ? 7 year

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ___ Date of ___

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ___ Injured at work?

23. SIGNATURE: W Royce Hodges M. D. or other

Address: Cumberland, Md Date signed 12/31/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (I)

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125-E)

CERTIFICATE OF DEATH

11655

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or Inst. (yrs., or mos., or days) 5 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town CRELLIN Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME REAM, ALVIN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife PAULINE STINEBAUGH REAM

6(c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 5, 1913

8. AGE: Years	Months	Days	If less than one day
26	1	23	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation MERCHANT

11. Industry or business

FATHER — 12. Name CHARLES W. REAM

FATHER — 13. Birthplace MARYLAND

MOTHER — 14. Maiden name IDA M. LEE

MOTHER — 15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 30, 1939 (month) (day) (year)

Cemetery or crematory Oakland, Maryland

Location Same

18. Funeral director Emory Bolden

Address Oakland, Maryland

18. Dec. 30 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 28 19 39, at 4:47 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-23-1939, to 12-28-1939 and that I last saw him alive on 12-28-1939

Immediate cause of death	DURATION
Acute Hepatitis	2 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 12/30/39

RECEIVED
JAN 6 1948
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

11656

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or insl. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Oldtown Road

(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR:

3. (a) FULL NAME: Baby Girl Rhodes (Premature)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: None.

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 14, 1939

8. AGE: Years	Months	Days	If less than one day
NB			1 hrs. 45 min.

9. Birthplace: Memorial Hospital (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Harley Rhodes

13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Nellie Baldwin

15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. (Burial, cremation, or removal. Which?) Cremation Date thereof (month) Dec (day) 14 (year) 39

Cemetery or crematory: Memorial Hospital

Location:

18. Funeral director:

Address:

19. (Date rec'd by registrar) Dec. 19, 1939 J. P. Franklin, M. D. Registrar

DR. R. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14, 1939, at 4:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1939, to Dec 14 1939

and that I last saw h[illegible] alive on Dec 14/39, 19

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dwight Reynolds M.D. M. D. or other

Address: City Date signed: Dec 16/39

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-C)

11657

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 20 yrs

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Allegany Hospital
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Rockey

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) ~~Dont Know~~ 1864

8. AGE: Years 75 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Retired

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden name "
15. Birthplace

16. Informant Allegany Hosp.

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 18 1939 (month) (day) (year)

Cemetery or crematory St Patricks Cem

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland Md

19. Dec. 18, 1939 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16th 1939, at 5:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1st 1939, to Dec 16 1939, and that I last saw him alive on Dec 15 1939.

Immediate cause of death Chronic Myocarditis with Congestive Heart failure

Due to

Due to

Other conditions Arterio sclerosis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. C. Bowen M.D.
M. D. or other

Address Cumberland Date signed 12-16-39

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1940
BUREAU V. S.

11658

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 235 Maryland ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 35 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 235 Maryland Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Smith Dewitt Samuels

3. (b) Social Security Number 215-05-2428

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Susan Rigglemon Samuels

8 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) April 28, 1881

8. AGE: Years 58 Months 8 Days 3 If less than one day ___ hrs. ___ min.

9. Birthplace Upperstock, Pendleton - W. Va. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER

12. Name Erasmus Asbury Samuels

13. Birthplace Mt Solon Va. Augusta Co

MOTHER

14. Maiden name Phoeba Virginia Lough

15. Birthplace Deer Run. W Va - Pendleton Co

16. Informant Mrs. Dewitt Samuels

Address Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2, 1940 (month) (day) (year)

Cemetery or crematory Philos

Location Westernport, Md.

18. Funeral director D. S. Boal

Address Westernport, Md.

19. Jan. 2 1940 (Date rec'd by registrar) A. Gaynbaker Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1939, at 8:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 1935, to Dec. 31 1939, and that I last saw him alive on Dec. 30 1939.

Immediate cause of death	DURATION
Hypertension, Arteriosclerosis	4 Years
Chronic Nephritis with Edema	2 Years
Due to	
Due to	
Other conditions Uremia	2 Days

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul R Wilson M.D. M. D. or other

Address Piedmont, W. Va. Date signed 1-1-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

11659

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Alleghany

City or town: Westernport (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 405 Walnut Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): about 60 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Alleghany

City or town: Westernport Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 405 Walnut Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William Herbert Seaber

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Beulah E. Seaber nee Fisher

B(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1879

8. AGE:

Years	Months	Days	If less than one day
60	1	26	hrs. min.

9. Birthplace: Piedmont, Mineral, West Va. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Singer Sewing Machine Co.

FATHER

12. Name: John F. Seaber

13. Birthplace: Clearspring, Md.

MOTHER

14. Maiden name: Mary Olive Payne

15. Birthplace: Grafton, W. Va.

1B. Informant: William H. Seaber, Jr.

Address: 405 Walnut St. Westport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 13, 1939 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

1B. Funeral director: D. S. Boal

Address: Barton, Md.

19. Dec. 13 1939 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11th 1939, at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11th 1939, to Dec 11th 1939, and that I last saw him alive on 12/11/39 19

Immediate cause of death: Sudden myocardial failure

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION: 12/12/39

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R W Reeves M. D. or other

Address: Westernport Md. Date signed: 12/12/39

RECEIVED
JAN 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-A)

CERTIFICATE OF DEATH

#8077 11660

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 740 No. Mechanic St

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 9 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 740 No. Mechanic St. (if rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Miss Madeline E. Shaffer

3. (b) Social Security Number: 217-10-5384

4. Sex: F.

5. Color or race: W.

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 23 - 1914

8. AGE: Years: 25 Months: 5 Days: 15 If less than one day: hrs. min.

9. Birthplace: Penna. (Town, county, and state)

10. Usual occupation: Weaver & Spinner

11. Industry or business: Silk - (Celanese)

FATHER

12. Name: Harry Shaffer

13. Birthplace: Penna

MOTHER

14. Maiden name: Lola Garner

15. Birthplace: Penna

16. Informant: Harry Shaffer

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 10 - 39 (month) (day) (year)

Cemetery or crematory: Lutheran Cem - Inc.,

Location: Cumberland Md - R.F.D.

16. Funeral director: V. L. Lemperen

Address: Cumberland Md

19. Dec. 9, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8 - 1939, at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1939, to December 8, 1939, and that I last saw h or alive on December 8, 1939.

Immediate cause of death: Carcinomatous metastasis from carcinoma of ovaries

DURATION: 1 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings: Of operations: Carcinoma both ovaries with metastasis

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James T. Johnson Jr. M.D. M. D. or other

Address: Cumberland, Md Date signed: 12-9-39

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

11661

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Hampshire

City or town: Greenspring Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ✓
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary Jane Shanholtz

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Brittain F. Shanholtz

6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1876

8. AGE: Years 63 | Months 3 | Days 20 | If less than one day ___ hrs. ___ min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: John Crock
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Susan Kerns Crock
15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 25-1939 (month) (day) (year)

Cemetery or crematory: Forrest Glen

Location: Greenspring. W Va

18. Funeral director: Thrush's.

Address: Romney W Va

19. Dec. 25 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

DR. R. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23, 1939, at 3:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/21/39 19 , to 12/23/39 19 , and that I last saw her alive on 12/23/39 19 .

Immediate cause of death: Cerebral Hemorrhage

Due to: Hypertension

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Richard J. Williams M.D. M. D. or other

Address: 34 Va. Ave. Date signed: 12/26/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 8 1910
BUREAU V. S.

WITHIN CORPORATE LIMITS.

11662

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 da.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 535 N. Centre
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Ella Smith

3. (b) Social Security Number: None

4. Sex: Fem.

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Richard Smith

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1869

8. AGE: Years: 70 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Penna.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: ????? Davis
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Harvey Smith

Address: 535 N. Centre St. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1939 (month) (day) (year)

Cemetery or crematory: Centenery Cem.

Location: State Line on Bedford Road

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Dec. 8, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 7 1939, at 5A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6 1939, to December 7 1939, and that I last saw her alive on December 7 1939.

Immediate cause of death	DURATION
Diabetic Coma	2 days
Due to Diabetes Mellitus	? 3 ?
~~Due to~~ Cardio Vascular Renal Disease	?
Other conditions Chronic Nephritis	?
Pneumoconiosis	?

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 119 Bedford St. Date signed: 12/8/39

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

11663

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland, Md. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 121 Springdale St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 121 Springdale St. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward Snyder

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name ~~of husband or~~ wife Mary Snyder

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1874

8. AGE: Years 65 Months 8 Days 27 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Tin Mill

11. Industry or business

FATHER

12. Name John H. Snyder

13. Birthplace Germany

MOTHER

14. Maiden Name Sarale Shank

15. Birthplace Va.

16 (a) Informant Mary Snider

(b) Address 121 Springdale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4 1939 (month) (day) (year)

(c) Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18 (a) Funeral director Louis Stein Inc.

(b) Address 117 Fredrick St. Cumb. Md.

19 (a) Dec 3, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Dec 1 1939, at 11 P.M. 25

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 18 1939, to Dec 1 1939, and that I last saw him alive on Dec 1 1939.

Immediate cause of death Chronic nephritis — Duration 2 yrs.

Due to back pressure from urinary obstruction.

Due to

Other conditions Hypertrophied prostate — 2 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy multiple abscesses of both kidneys. Large pelves both kidneys, dilated ureters " "

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(c) Means of injury

23. Signature R. A. Trevaskis M.D. M. D. or other

Address Cumberland, Md. Date signed Dec 2-39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

11664

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 mos. 23 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 320 Race Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ruth Josephine Spriggs

3. (b) Social Security Number 214-05-8989

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas H. Spriggs

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 12, 1897

8. AGE: Years 42 | Months 4 | Days 5 | If less than one day ____ hrs. ____ min.

9. Birthplace: Ellerslie Md.
(Town, county, and state)

10. Usual occupation: Laundry work

11. Industry or business: Union Laundry Co.

FATHER
12. Name: John W. Karns
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Crawford
15. Birthplace: Maryland

16. Informant: Mrs. Mary Snyder
Address: 120 Mullen St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 19, 1939. (month) (day) (year)

Cemetery or crematory: S. S. Peter and Paul Cem.

Location: Cumberland, Md.

18. Funeral director: J. C. Nolford
Address: Cumberland, Md.

19. Dec. 19, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1939, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23 1939, to Dec. 16 1939, and that I last saw her alive on Dec 16 1939.

Immediate cause of death: Uremia

Due to: Hypertensive Cardio-vascular Renal Disease

~~Due to~~ with Edema

Other conditions: Severe Secondary Anemia
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION: 6 months; 2 years; ??

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: Samuel Jacobson M. D. or other
Address: 119 Bedford St. Date signed 12/17/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

CERTIFICATE OF DEATH

11665

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days) Since Born
Stay in this community (yrs., or mos., or days) Since Born

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Allegany
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Infant Stevens

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Infant

6 (b) Name of husband or wife none

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Stillborn Dec 17 1939

8. AGE: Years | Months | Days | If less than one day ____ hrs. ____ min.
Stillborn

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business none

FATHER
12. Name James Arthur Stevens
13. Birthplace Cumberland Md

MOTHER
14. Maiden name Martha Anna Anderson
15. Birthplace Frostburg Md

16. Informant James Arthur Stevens
Address 363 Centre St. City

17. Burial Date thereof Dec 20-39
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill
Location Cumberland Md

18. Funeral director V. L. Lemperman
Address Cumberland Md

Dec 20, 1939 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1939, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17 1939, to Dec 17 1939, and that I last saw him alive on Stillborn Dec 17 1939.

Immediate cause of death	DURATION
Stillborn	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. D. Stevens M. D. or other
Address 133 Va Ave Date signed 12/20/39

RECEIVED
JAN 6 1949
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (952)

CERTIFICATE OF DEATH

11666

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Allegany

City or town Ellerslie, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Ellerslie Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Mary Elizabeth Kelly Swauger

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife William F. Swauger

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1871

8. AGE: Years 69 Months 8 Days 7 If less than one day hrs. min.

9. Birthplace Cooks Mills, Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William Henry Kelly
13. Birthplace Penna.

MOTHER
14. Maiden name Mary Ellan Kelly
15. Birthplace Penna.

16. Informant Stanley Swauger

Address Ellerslie, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 18, 1939 (month) (day) (year)

Cemetery or crematory Madley Cemetery

Location Madley, Pa.

18. Funeral director Harvey H. Zeigler

Address Hyndman Pa.

19. Dec 18 1939 (Date rec'd by registrar) J. Lloyd Wage Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16th 1939, at 1A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11th 1939, to Dec 16 1939, and that I last saw her alive on Dec 15th 1939.

Immediate cause of death Cerebral Apoplexy. — DURATION 2 wks.

Due to Generalized Arteriosclerotic Cardio-Vascular Heart Disease with Hypertension. — 15 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Topper MD. M. D. or other

Address Hyndman Pa. Date signed 12/17/39.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

JAN 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

11667

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.:
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Symons

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 22, 1939

8. AGE: Years | Months | Days | If less than one day: 12 hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Charles Edgar Symons
13. Birthplace: Barton, Md.

MOTHER
14. Maiden name: Beulah Powell
15. Birthplace: Fitzmiller, Md.

16. Informant: Chas. E. Symons
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 23 1939 (month) (day) (year)

Cemetery or crematory: St. Peters Cemetery

Location: Westernport Md.

18. Funeral director: D. S. Bail

Address: Westernport Md

19. Dec. 23, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 22, 1939, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22 1939 to Dec. 22 1939, and that I last saw him alive on Dec. 22/39 19.

Immediate cause of death: Premature Birth 6½ mths — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. P. Franklin M.D.
M.D. or other

Address: 41 Greene St. Cumberland Date signed: Dec. 23/39

RECEIVED
JAN 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (748)

CERTIFICATE OF DEATH

11668

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH: Allegany
County
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 231 Race Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 231 Race Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Agnes Margaret White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Charles J. White
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 17, 1872

8. AGE: Years	Months	Days	If less than one day
67	0	8	hrs. min.

9. Birthplace: Bloomington, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: James Bouhen
13. Birthplace: Ireland

MOTHER
14. Maiden name: Ellen Halvey
15. Birthplace: Ireland

16. Informant: Mary D. White
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 27, 1939 (month) (day) (year)
Cemetery or crematory: St. Peter & Paul Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Dec. 26, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25/39 19__, at 5:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/25/39 19__ to 12/25/39 19__, and that I last saw h- alive on 12/25/39 19__

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Richard J. Williams, MD
M. D. or other
Address 24 Va. Ave. Date signed 12/26/39
Cumberland MD

RECEIVED
JAN 6 1910
BUREAU U. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

11669

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegheny

City or town: Cumberland Md. (If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution: Bedford Road-Rural

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Near Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Williams Rd. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs Pleasant Stottlemyer Wigfield

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife: George Wigfield

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15 1877

8. AGE: Years: 62 Months: 6 Days: 16 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Cornwell Stottlemyer

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Louisianna Brady

15. Birthplace: Maryland

16. Informant: Mrs Wigfield

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3 1939 (month) (day) (year)

Cemetery or crematory: Mt. Hermon

Location: Near Cumberland, Md.

18. Funeral director: Virgil L. Lemmon

Address: Cumberland Md.

19. Dec. 2, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 1 1939, at 8 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1939 to Dec 1 1939 and that I last saw h alive on Nov. 22 1939

Immediate cause of death: Cerebral arteriosclerosis — DURATION: ?

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: — Injured at work? —

23. SIGNATURE: W P Hodges, Jr., M.D.

Address: Cumberland, Md. M. D. or other

Date signed: 12/2/39

RECEIVED
JAN 6 1940
BUREAU V. S.

Outside of City Limits

CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(48)

11670

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Valley Road R.F.D. #3

City or town Cumberland Md - Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Valley Road, R.F.D. #3

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Near Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Valley Road, R.F.D. #3
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Dorleskia Wilson

3. (b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced Widowed

B (b) Name of husband or wife Emory

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14, 1868

8. AGE: Years 71 Months 4 Days 3 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name Upton H. Athey
13. Birthplace Md.

MOTHER
14. Maiden name Sarah Athey
15. Birthplace Md.

16. Informant Ersel A. Wilson

Address Same

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Dec. 20, 1939
(month) (day) (year)

Cemetery or crematory Cemetery

Location Mt Herman

18. Funeral director Virgil L. Lemmerer

Address Cumberland Md

19. Dec. 20 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Dr Wilson.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1939, to Dec 17 1939, and that I last saw her alive on Dec. 7 1939.

Immediate cause of death Intestinal obstruction

Carcinomatosis of abdomen

Due to Carcinoma uterus (adeno)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION
2 days
8 mos

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson M.D.
M. D. or other

Address Cumberland Md Date signed 12-18-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11671

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 312 Emily St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 29 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany.

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 312 Emily St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Gertrude Wilson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

8 (b) Name of husband or wife

8 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov 7, ~~1909~~ 1910

8. AGE:

Years	Months	Days	If less than one day
29	0	28	____ hrs. ____ min.

9. Birthplace Cumberland Allegany, Md.

(Town, county, and state)

10. Usual occupation Invalid at Home

11. Industry or business - Life

FATHER

12. Name Arthur James Wilson

13. Birthplace Allegany Co - Rush, Md.

MOTHER

14. Maiden name Yankey A. North

15. Birthplace Allegany Co - Rush, Md.

16. Informant Arthur J. Wilson

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 7 1939. (month) (day) (year)

Cemetery or crematory Hill Crest

Location Cumberland, Md.

19. Funeral director Jacob Hafer

Address Cumberland, Md

19. Dec. 6 39 J. P. Franklin, M.D. (Data rec'd by registrar) Registrar

C. H. Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec, 5, 1939, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1st 1939 to Dec 5 1939

and that I last saw her alive on Dec 4th 1939

	DURATION
Immediate cause of death Influenzal Pneumonia	5 days
Due to Influenza	6
Due to	
Other conditions Chronic Bronchitis	3 Mos

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. H. Owens M.D. M. D. or other

Address Cumberland Md. Date signed 12-6-39

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1940)

CERTIFICATE OF DEATH

11672

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 day

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Zihlman Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Green Row

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Arthur James Winebrenner

3. (b) Social Security Number 212-10-6340

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Viola Rose Winebrenner

6(c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1913

8. AGE: Years 26 | Months 4 | Days 11 | If less than one day ____ hrs. ____ min.

9. Birthplace Frostburg, Allegany, Md.

(Town, County, and state)

10. Usual occupation Moulder

11. Industry or business Refractory Plant,

FATHER 12. Name Henry Winebrenner

13. Birthplace Garrett County, Md.

MOTHER 14. Maiden name Stella Winebrenner

15. Birthplace Garrett County, Md.

16. Informant Mrs Arthur J. Winebrenner

Address Zihlman Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22, 1939 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg Md.

18. Funeral director Jacob Hofer

Address Frostburg Md.

19. 12-22 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

Cobey

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1939, at 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 18 1939 to Dec. 19 1939, and that I last saw h[illegible] on Dec. 19. 1939

	DURATION
Immediate cause of death Paralysis of respiratory + Cardiac Centers	
Due to Fracture of Spine	
Due to Fall of a Tree	
Other conditions 4 fractured ribs + Internal Injuries	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12-18-39

Where did injury occur? Zihlman Allegany Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where) Tree

Means of injury Tree fell on him Injured at work? No

23. SIGNATURE J. A. Cobey M. D. or other

Address Frostburg Md Date signed 12-20-39

RECEIVED
JAN 3 1940
REAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

11673

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 506 Linden St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 506 Linden St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: George Winfield

3. (b) Social Security Number: 220-03-7596

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Hensler

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 17, 1866

8. AGE: Years: 73 Months: 6 Days: 2. If less than one day ____ hrs. ____ min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Brewer

11. Industry or business: Cumberland Brewing Co.

FATHER
12. Name: William Winfield
13. Birthplace: Germany

MOTHER
14. Maiden name: Francis Fisher
15. Birthplace: Germany

16. Informant: Anna Hensler

Address: 506 Linden St

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Dec. 22, 1939
(month) (day) (year)

Cemetery or crematory: St. Peter + Pauls Cem.

Location: Cumberland Md

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md

19. Dec. 21, 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 1939, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937 19__, to Dec 19 1939, and that I last saw him alive on Dec 16 1939.

Immediate cause of death: Acute Dilatation of Heart

Due to: Chronic Myocarditis and Endocarditis

Due to: Chronic Nephritis and Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: at once; end years; end years

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: F. Alan G. Wenner MD
M. D. or other

Address: 41 Frame Ave Date signed: Dec 20 39

Cumberland Md

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

11674

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 510 Rose Hill Ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 510 Rose Hill Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Walter Alger Gingling

3. (b) Social Security Number 705-10-7900

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary L. Smitten
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1876

8. AGE:

Years	Months	Days	If less than one day
63	9	3	hrs. min.

9. Birthplace Hagerstown, Washington Co. Md.
(Town, county, and state)
10. Usual occupation General freight agent
11. Industry or business Rail Road, W. Md.
FATHER 12. Name Allen Gingling
13. Birthplace Md.
MOTHER 14. Maiden name Clara Fechtig
15. Birthplace Md.
18. Informant Mrs Mary L. Gingling
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19 39 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland Md.
18. Funeral director Louis Stein Inc.
Address Cumberland Md
19 Dec 19, 19 39 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17-1939 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-2-1939 to 12-17-1939 and that I last saw him alive on 12-16-1939

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to Coronary artery disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 12/18/39

RECEIVED
DEC 30 1939
BUREAU V. S.